MEDICAL RECORD	Request for Performance of Procedures: Angiography with Indocyanine Green Dye

EXPLANATION OF THE PROCEDURE: Angiography is a procedure where a rapid series of photographs will be taken to study the blood flow in two parts of your eye – the choroid and the retina. To make it easier for us to see the blood flow in your eye, we will inject a dye called Indocyanine Green. The dye is usually injected into a vein in the arm, forearm, or hand. The dye leaving your body will make your stool a greenish color for a little while. This is a normal result of the natural processes that remove the dye from your body.

POSSIBLE RISKS AND COMPLICATIONS: Some patients who are given the dye have a reaction to it. The types of reactions that have been reported are headache, nausea, upset stomach, vomiting, light-headedness, fainting, hives or itching. All adverse reactions will be treated with proper medication.
Please note: IF YOU HAVE AN ALLERGY TO IODINE OR CONTRAST DYE OR SHELLFISH, PLEASE INFORM YOUR PHYSICIAN. YOU MAY BE ALLERGIC TO INDOCYANINE GREEN DYE.

ACKNOWLEDGMENTS:
1. I understand that photographs will be taken during this procedure. I consent to the use of these photographs for training and scientific purposes so long as neither the pictures nor any written words accompanying them identify who I am.
2. I request that the angiography procedure be done. I also agree that while you are doing the angiography, you may do additional services that the professional staff of the Warren Grant Magnuson Clinical Center judge to be needed or useful.
3. I understand that no guarantees of any kind regarding this procedure have been made to me.
4. I understand this procedure is to be performed by, or under the direction of, Dr._____.

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1. **Physician**: I have counseled this patient as to the nature of the proposed procedure, the risks involved, and the expected results, as described above.

_____ _____
(Signature of Physician) (Date)

2. **Patient**: I understand the nature of the proposed procedure, the risks involved, and the expected results, as described above, and hereby request that the procedure be performed.

_____ _____
(Signature of Patient) (Date)

3. **Sponsor or Guardian**: I, _____sponsor/guardian of _____ understand the nature of the proposed procedure, the risks involved, and the expected results, as described above, and hereby request that such procedures be performed.

_____ _____
(Signature of Sponsor/Guardian) (Date)

4. **Witness**

_____ _____
(Signature of Witness excluding members of operating team) (Date)